		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032839

Facility Name: GLENWOOD HEALTHCARE & REHAB

Address: 19330 S. COTTAGE GROVE AVE (Number) GLENWOOD (City) 60425 (Zip Code)

County: COOK

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-3532094

Date of Initial License for Current Owners: 9/1/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD. 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	184	TOTALS	184	67,160	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,243	4,243	8
9	SNF/PED					9
10	ICF	39,112	4,746	1,799	45,657	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,112	4,746	6,042	49,900	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.30%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 4,243

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	201,757	11,930	11,369	225,056		225,056		225,056			1
2	Food Purchase		214,127		214,127		214,127	(12,523)	201,604			2
3	Housekeeping	218,716	25,992		244,708		244,708	536	245,244			3
4	Laundry	68,359	24,891	289	93,539		93,539		93,539			4
5	Heat and Other Utilities			110,618	110,618		110,618	864	111,482			5
6	Maintenance	59,271	31,072	21,354	111,697		111,697	2,228	113,925			6
7	Other (specify):* SCAVENGER			9,562	9,562		9,562		9,562			7
8	**TOTAL General Services**	548,103	308,012	153,192	1,009,307		1,009,307	(8,895)	1,000,412			8
	B. Health Care and Programs											
9	Medical Director			10,500	10,500		10,500		10,500			9
10	Nursing and Medical Records	1,453,012	154,154	496,498	2,103,664		2,103,664	22,950	2,126,614			10
10a	Therapy		3,745	5,560	9,305		9,305		9,305			10a
11	Activities	160,444		4,282	164,726		164,726		164,726			11
12	Social Services	32,330		1,856	34,186		34,186		34,186			12
13	Nurse Aide Training			6,175	6,175		6,175		6,175			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,645,786	157,899	524,871	2,328,556		2,328,556	22,950	2,351,506			16
	C. General Administration											
17	Administrative	44,851		86,300	131,151		131,151	(26,314)	104,837			17
18	Directors Fees											18
19	Professional Services			97,433	97,433		97,433	15,219	112,652			19
20	Dues, Fees, Subscriptions & Promotions			71,855	71,855		71,855	(24,535)	47,320			20
21	Clerical & General Office Expenses	120,595	21,105	205,731	347,431		347,431	(45,796)	301,635			21
22	Employee Benefits & Payroll Taxes			341,923	341,923		341,923	25,299	367,222			22
23	Inservice Training & Education											23
24	Travel and Seminar			450	450		450	10,558	11,008			24
25	Other Admin. Staff Transportation			9,000	9,000		9,000	10,827	19,827			25
26	Insurance-Prop.Liab.Malpractice			90,178	90,178		90,178	5,985	96,163			26
27	Other (specify):*											27
28	**TOTAL General Administration**	165,446	21,105	902,870	1,089,421		1,089,421	(28,757)	1,060,664			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,359,335	487,016	1,580,933	4,427,284		4,427,284	(14,702)	4,412,582			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB #0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			47,937	47,937		47,937	171,871	219,808			30
31	Amortization of Pre-Op. & Org.							24,546	24,546			31
32	Interest			43,354	43,354		43,354	500,135	543,489			32
33	Real Estate Taxes			412,771	412,771		412,771		412,771			33
34	Rent-Facility & Grounds			757,050	757,050		757,050	(749,679)	7,371			34
35	Rent-Equipment & Vehicles			821	821		821					35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,261,933	1,261,933		1,261,933	(53,127)	1,207,985			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			191,549	191,549		191,549		191,549			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			100,740	100,740		100,740		100,740			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			292,289	292,289		292,289		292,289			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,359,335	487,016	3,135,155	5,981,506		5,981,506	(67,829)	5,912,856			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(20,595)	30		9
10	Interest and Other Investment Income	(418)	32		10
11	Discounts, Allowances, Rebates & Refunds	(12,132)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(391)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,959)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,415)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,671)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	1,342	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,239)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(6,590)	SCHED	34
35	Other- Attach Schedule		ATTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (6,590)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (67,829)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GLENWOOD HEALTHCARE & REHAB

ID# 0032839

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEF MAINTENTANCE	$ 1,342	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	1,342		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,523)	0	0	0	0	0	0	0	0	0	0	(12,523)	2
3	Housekeeping	0	0	536	0	0	0	0	0	0	0	0	536	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	864	0	0	0	0	0	0	0	0	864	5
6	Maintenance	1,342	0	886	0	0	0	0	0	0	0	0	2,228	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,181)	0	2,286	0	0	0	0	0	0	0	0	(8,895)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	22,950	0	0	0	0	0	0	0	0	22,950	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	22,950	0	0	0	0	0	0	0	0	22,950	16
	C. General Administration													
17	Administrative	0	(86,300)	59,986	0	0	0	0	0	0	0	0	(26,314)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,650	12,569	0	0	0	0	0	0	0	0	15,219	19
20	Fees, Subscriptions & Promotions	(25,086)	0	551	0	0	0	0	0	0	0	0	(24,535)	20
21	Clerical & General Office Expenses	(3,959)	(170,611)	128,774	0	0	0	0	0	0	0	0	(45,796)	21
22	Employee Benefits & Payroll Taxes	0	0	25,299	0	0	0	0	0	0	0	0	25,299	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	10,558	0	0	0	0	0	0	0	0	10,558	24
25	Other Admin. Staff Transportation	0	0	10,827	0	0	0	0	0	0	0	0	10,827	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,985	0	0	0	0	0	0	0	0	5,985	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,045)	(254,261)	254,549	0	0	0	0	0	0	0	0	(28,757)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(40,226)	(254,261)	279,785	0	0	0	0	0	0	0	0	(14,702)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(20,595)	188,625	3,841	0	0	0	0	0	0	0	0	171,871	30
31	Amortization of Pre-Op. & Org.	0	24,546	0	0	0	0	0	0	0	0	0	24,546	31
32	Interest	(418)	500,455	98	0	0	0	0	0	0	0	0	500,135	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(757,050)	7,371	0	0	0	0	0	0	0	0	(749,679)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(21,013)	(43,424)	11,310	0	0	0	0	0	0	0	0	(53,127)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(61,239)	(297,685)	291,095	0	0	0	0	0	0	0	0	(67,829)	45

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRAD ALTER	22.83	SCHEULDE ATTACHED		CERTIFIED HEALTI	SKOKIE	BOOKKEEPING/
HOWARD GELLER	38.04			MANAGEMENT		MANAGEMENT
CYNTHIA CHOW	39.13			CHM THERAPY	SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 86,300	CERTIFIED HEATLH MANAGEMENT		$	$ (86,300)	1
2	V	21	BOOKKEEPING	171,380	CERTIFIED HEATLH MANAGEMENT			(171,380)	2
3	V								3
4	V								4
5	V	34	RENT	757,050	GLENWOOD TERRACE LLC			(757,050)	5
6	V								6
7	V	19	PROFESSIONAL FEES		" "		2,650	2,650	7
8	V	30	DEPRECIATION		" "		188,625	188,625	8
9	V	31	AMORTIZATION		" "		24,546	24,546	9
10	V	32	INTEREST		" "		500,455	500,455	10
11	V	21	OFFICE EXPENSE		" "		769	769	11
12	V								12
13	V								13
14	Total			$ 1,014,730			$ 717,045	$ * (297,685)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$			$ 536	$ 536	15
16	V	5	ELECTRICITY & GAS				864	864	16
17	V	6	MAINTENANCE				886	886	17
18	V	10	NURSING/MEDICAL RECORDS				22,950	22,950	18
19	V	17	ADMIN SALARIES				59,986	59,986	19
20	V	19	PROFESSIONAL FEES				12,569	12,569	20
21	V	20	FEES, SUBSCRIPTIONS				551	551	21
22	V	21	OFFICE EXPENSE				128,774	128,774	22
23	V	22	EMPLOYEE BENEFITS				25,299	25,299	23
24	V	24	TRAVEL/SEMINAR				10,558	10,558	24
25	V	25	TRANSPORTATION				10,827	10,827	25
26	V	26	INSURANCE				5,985	5,985	26
27	V	30	DEPRECIATION				3,841	3,841	27
28	V	32	INTEREST				98	98	28
29	V	34	OFFICE RENT				7,371	7,371	29
30	V	35	EQUIPMENT RENT				0		30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 291,095	$ * 291,095	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 81,575	17-7	1
2	HOWARD GELLER		ADMINISTRATIVE		SCHEDULE ATTACHED			MGMT FEE	4,725	19-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 86,300		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	279,537	8	$ 3,000	$	49,900	$ 536	1
2	5	ELECTRICITY & GAS	" " "	279,537	8	4,839		49,900	864	2
3	6	MAINTENANCE	" " "	279,537	8	4,965		49,900	886	3
4	10	NURSING/MEDICAL RECORDS	" " "	279,537	8	128,566	128,566	49,900	22,950	4
5	17	ADMIN SALARIES	" " "	279,537	8	336,038	336,038	49,900	59,986	5
6	19	PROFESSIONAL FEES	" " "	279,537	8	70,412		49,900	12,569	6
7	20	FEES, SUBSCRIPTIONS	" " "	279,537	8	3,089		49,900	551	7
8	21	OFFICE EXPENSE	" " "	279,537	8	721,384	572,980	49,900	128,774	8
9	20	EMPLOYEE BENEFITS	" " "	279,537	8	141,722		49,900	25,299	9
10	24	TRAVEL/SEMINAR	" " "	279,537	8	59,144		49,900	10,558	10
11	25	TRANSPORTATION	" " "	279,537	8	60,651		49,900	10,827	11
12	26	INSURANCE	" " "	279,537	8	33,528		49,900	5,985	12
13	30	DEPRECIATION	" " "	279,537	8	21,518		49,900	3,841	13
14	32	INTEREST	" " "	279,537	8	549		49,900	98	14
15	34	OFFICE RENT	" " "	279,537	8	41,293		49,900	7,371	15
16	35	EQUIPMENT RENT	" " "	279,537	8				0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,630,698	$ 1,037,584		$ 291,095	25

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BARRY KIRSCHENBAUM	X		MORTGAGE	$48,244.00	1/1/99	$ 5,796,000	$ 5,586,814	1/1/24	8.9000	$ 500,455	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL	DEMAND					PRIME+	41,397	6
7												7
8	RELATED PARTY/OTHER										2,055	8
9	TOTAL Facility Related				$48,244.00		$ 5,796,000	$ 5,586,814			$ 543,907	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,796,000	$ 5,586,814			$ 543,907	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	400,691	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	402,704	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,013	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	410,758	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	412,771	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	332,223	8
	1997	345,013	9
	1998	351,119	10
	1999	392,834	11
	2000	402,704	12

Assumes 2.5% increase based on prior years increase

Payment on line 2 applies to the 2000 tax year

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GLENWOOD HEALTHCARE & REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0032839

CONTACT PERSON REGARDING THIS REPORT Don Fiets

TELEPHONE (847) 647-4700 x40 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-10-201-009-0000	Glenwood Terrace	$ 402,704.00	$ 402,704.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 402,704.00	$ 402,704.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,010 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1999	$ 322,000	1
2					2
3	TOTALS			$ 322,000	3

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	184		1999		$ 5,474,000	$ 140,359	39	$ 140,359	$	$ 421,077	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1988	20,662	656	30	389	(267)	8,990	9
10	LEASEHOLD IMPROVEMENTS			1989	4,071	129	30	136	7	1,700	10
11	LEASEHOLD IMPROVEMENTS			1990	28,171	894	30	939	45	10,799	11
12	LEASEHOLD IMPROVEMENTS			1991	31,712	1,007	30	1,057	50	11,099	12
13	LEASEHOLD IMPROVEMENTS			1992	10,071	320	30	336	16	3,192	13
14	LEASEHOLD IMPROVEMENTS			1993	4,810	123	30	160	37	1,423	14
15	LEASEHOLD IMPROVEMENTS			1994	17,744	455	30	592	137	4,439	15
16	LIGHT FIXTURES, ROOM SIGNS, HAND RAILS			1995	6,343	162	39	162		1,275	16
17	HEATING/AIR CONDITIONING			1995	12,515	321	39	321		2,501	17
18	NURSING STATION			1995	10,384	266	39	266		1,984	18
19	SPRINKLER/LANUDRY VENTILATION REPAIR			1995	2,360	61	39	61		441	19
20	LAMPS, VIDEO CAMERA, PANIC DEVICE, WATER COOLER			1996	3,650	94	39	94		625	20
21	EXIT & OUTDOOR SIGNS			1996	4,237	108	39	108		700	21
22	WINDOWS, DOORS, CEILING TILES/CARPET			1996	25,090	643	39	643		3,989	22
23	HVAC WIRING REPAIR			1996	1,540	40	39	40		245	23
24	TIME CLOCKS,HEAT & COOL UNITS			1997	7,022	180	39	180		818	24
25	NURSE STATION			1997	5,615	144	39	144		654	25
26	FLOOR/CEILING TILES, COUNTER & CABINETS			1997	21,659	555	39	555		2,595	26
27	DOORS, LIGHTS, SIGHNS			1997	14,825	380	39	380		1,798	27
28	BURNERS & ELECTRICAL FOR WASHER			1997	1,964	50	39	50		227	28
29	SIGNS, PATIO SURFACE			1998	6,994	466	15	466		1,631	29
30	WINDOWS & INSTALLATION			1998	18,944	486	39	486		1,924	30
31	KITCHEN REMODEL			1998	50,500	1,295	39	1,295		5,128	31
32	ELECTRIC WORK			1998	7,545	193	39	193		684	32
33	CARPET, WALLPAPER, HANDRAIL, BUMPER GUARD			1998	79,382	2,036	39	2,036		6,637	33
34	GENERATOR			1999	56,533	1,450	39	1,450		4,291	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HEAT AND AIR CONDITIONER	1999	$ 14,673	$ 376	39	$ 376	$	$ 956	37
38	VINYL FLOORING AND TILES	1999	5,505	141	39	141		347	38
39	ROOF AND TUCKPOINT	1999	59,360	1,522	39	1,522		3,616	39
40	AIR CONDITIONER/COMPRESSOR	2000	9,868	2,417	20	493	(1,924)	1,903	40
41	ROOF REPAIR	2000	3,750	136	27.5	136		244	41
42	VINYL TILE/COVE BASE	2000	19,277	700	27.5	700		1,188	42
43	ALARM WORK	2000	3,848	140	27.5	140		166	43
44	DRAPERIES	2001	1,750	56	27.5	56		56	44
45	ELECTRICAL WORK	2001	5,550	126	27.5	126		126	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,051,924	$ 158,487		$ 156,588	$ (1,899)	$ 509,468	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 300,243	$ 27,427	$ 30,024	$ 2,597	10 YRS	$ 176,964	71
72	Current Year Purchases	19,466	2,382	984	(1,398)	10 YRS	984	72
73	Fully Depreciated Assets	4,850					4,850	73
74	RELATED PARTY	322,115	52,107	32,212	(19,895)			74
75	TOTALS	$ 646,674	$ 81,916	$ 63,220	$ (18,696)		$ 182,798	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,020,598	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 240,403	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 219,808	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (20,595)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 692,266	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 821 Description: SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 57,503	$		$ 57,503	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,603			3,603	2
3	Licensed Recreational Therapist	39-3	hrs							3
4	Licensed Physical Therapist	39-3	hrs			130,443			130,443	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 191,549	$		$ 191,549	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 82,000)	886,853		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	161,035		6
7	Other Prepaid Expenses	2,933		7
8	Accounts Receivable (owners or related parties)	467,036		8
9	Other(specify): REAL ESTATE ESCROW	205,221		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,723,078	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	154,774		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	577,925		15
16	Equipment, at Historical Cost	413,702		16
17	Accumulated Depreciation (book methods)	(431,534)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 714,867	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,437,945	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 480,594	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,500		28
29	Short-Term Notes Payable	34,159		29
30	Accrued Salaries Payable	136,186		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,806		31
32	Accrued Real Estate Taxes(Sch.IX-B)	410,758		32
33	Accrued Interest Payable	2,055		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,087,058	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	144,320		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	LINE OF CREDIT	581,850		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 726,170	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,813,228	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 624,717	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,437,945	$	48

***(See instructions.)**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 193,458	1
2	Restatements (describe):		2
3	W/O DUE TO/FROM MEDICARE	194	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 193,652	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	431,065	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 431,065	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 624,717	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,346,484	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,346,484	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	53,955	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 53,955	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	12,132	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,132	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,412,571	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,009,307	31
32	Health Care	2,328,556	32
33	General Administration	1,089,421	33
	B. Capital Expense		
34	Ownership	1,261,933	34
	C. Ancillary Expense		
35	Special Cost Centers	191,549	35
36	Provider Participation Fee	100,740	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,981,506	40
41	**Income before Income Taxes (line 30 minus line 40)****	431,065	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 431,065	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,080	$ 43,659	$ 20.99	1
2	Assistant Director of Nursing	3,273	3,274	52,221	15.95	2
3	Registered Nurses	14,387	14,532	225,833	15.54	3
4	Licensed Practical Nurses	28,882	29,191	386,586	13.24	4
5	Nurse Aides & Orderlies	64,013	65,781	640,564	9.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,745	5,225	62,389	11.94	8
9	Activity Director	3,952	4,160	56,792	13.65	9
10	Activity Assistants	14,950	15,876	103,652	6.53	10
11	Social Service Workers	3,046	3,110	32,330	10.40	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	35,148	16.90	13
14	Head Cook	3,719	4,039	35,920	8.89	14
15	Cook Helpers/Assistants	17,729	18,709	130,689	6.99	15
16	Dishwashers					16
17	Maintenance Workers	4,572	4,676	59,271	12.68	17
18	Housekeepers	25,067	25,916	218,716	8.44	18
19	Laundry	8,958	9,390	68,359	7.28	19
20	Administrator	1,976	2,080	44,851	21.56	20
21	Assistant Administrator					21
22	Other Administrative	1,692	1,732	34,996	20.21	22
23	Office Manager	5,152	5,360	58,694	10.95	23
24	Clerical	2,614	2,862	26,905	9.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	978	978	7,586	7.76	31
32	Other Health C: staffing coord	1,119	1,175	14,663	12.48	32
33	Other(specify) care plan coord	865	957	19,511	20.39	33
34	TOTAL (lines 1 - 33)	215,641	223,183	$ 2,359,335 *	$ 10.57	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 11,369	L1 C3	35
36	Medical Director		8,500	L18 C3	36
37	Medical Records Consultant		13,489	L10 C3	37
38	Nurse Consultant		9,375	L10 C3	38
39	Pharmacist Consultant		1,215	L10 C3	39
40	Physical Therapy Consultant		1,215	L10 C3	40
41	Occupational Therapy Consultant		329	L10 C3	41
42	Respiratory Therapy Consultant		3,986	L10 C3	42
43	Speech Therapy Consultant		30	L10 C3	43
44	Activity Consultant		2,342	L11 C3	44
45	Social Service Consultant		1,856	L12 C3	45
46	Other(specify) NURSE AID TRAINING			L10 C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 53,706		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 2,009	L10 C3	50
51	Licensed Practical Nurses		46,615	L10 C3	51
52	Nurse Aides		417,844	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 466,468		53

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Celeste Phillips	Admin.	0	$ 44,851
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 44,851

B. Administrative - Other

Description	Amount
Management Fees	$ 86,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 86,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
RELATED PARTY		15,219
SCHEDULE ATTACHED		97,433
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 112,652

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,175
Unemployment Compensation Insurance	16,058
FICA Taxes	180,489
Employee Health Insurance	83,314
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other	(113)
RELATED PARTY	25,299
TOTAL (agree to Schedule V, line 22, col.8)	$ 367,222

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	32,608
Health Care Worker Background Check	
(Indicate # of checks performed)	
ADV/PROMO NON PATIENT	23,414
DUES, BOOKS, SUBSC	11,718
LICENSE, PERMITS	2,443
ADV - YELLOW PAGES	1,671
RELATED PARTY	551
Less: Public Relations Expense	( )
Non-allowable advertising	(23,414)
Yellow page advertising	(1,671)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,320

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	80
Seminar Expense	
	370
RELATED PARTY	10,558
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,008

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING/DECORATIN	1996	$	3	$ 2,044	$ 1,022	$	$	$	$	$	$	$
2	PAINTING/DECORATIN	1997		3	3,512	3,512	1,756						
3	PAINTING/DECORATIN	1998		3	672	1,345	1,345	672					
4	PAINTING/DECORATIN	1999		3		355	670	670	336				
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$ 6,228	$ 6,234	$ 3,771	$ 1,342	$ 336	$	$	$	$

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC $8,602**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **NO**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **253** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **100,740**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: GLENWOOD HEALTHCARE & REHAB #0032839 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,369	
	REPAIRS & MAINTENANCE		0	
			0	11,369
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		289	
			0	289
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		30,514	
	ELECTRICITY		62,978	
	WATER		17,126	
	CABLE TV - LOBBY		0	
			0	110,618
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,430	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,083	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,078	
	FIRE SERVICE		4,763	
	SCAVENGER			
	EQUIPMENT RENTAL		0	
				21,354
7	**OTHER**			
	SCAVENGER		9,562	
	SECURITY SERVICE		0	9,562
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	10,500	10,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	469,778	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		2,641	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	13,489	
	PHARMACY CONSULTANT	XVIII B 39-2	1,215	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
			0	
	NURSE PROGRAM CONSULT.		9,375	
	RN CONSULTANT	XVIII B 38-2		
			0	496,498
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	448	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	767	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	329	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	3,986	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	30	5,560
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOM			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,342	
	ACTIVITY PROGRAM EXP		1,940	4,282
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,856	
			0	1,856
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	6,175	6,175

Facility Name & ID#: GLENWOOD HEALTHCARE & REHAB **#0032839** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	86,300	86,300
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,109	
	ADMINISTRATIVE CONSULTANTS	XIX C	50,563	
	PROFESSIONAL FEES	XIX C	38,761	
			0	97,433
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	23,415	
	EMPLOYEE WANT ADS	XIX F	32,608	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	11,718	
	LICENSES & PERMITS	XIX F	2,443	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,671	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	71,855
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		3,167	
	EQUIPMENT REPAIR & MAINTENANCE		3,154	
	OUTSIDE CLERICAL SERVICES		171,380	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,959	
	HOME OFFICE EXPENSES		0	
	THEFT & DAMAGE LOSS		99	
	TELEPHONE		16,078	
	POSTAGE		2,878	
	AUTO LEASING		5,016	
				205,731

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	180,489	
	UNEMPLOYMENT COMPENSATION	XIX D	16,058	
	WORKERS COMPENSATION INSURANC	XIX D	62,175	
	HOSPITALIZATION INSURANCE	XIX D	83,314	
	EMPLOYEE BENEFITS - OTHER	XIX D	(113)	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	OTHER	XIX D	0	341,923
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	370	
	TRAVEL	XIX G	80	
			0	
			0	450
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,000	9,000
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		90,179	90,178
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,580,933